Family & Social Services Administration
Division of Disability, Aging & Rehabilitative Services
Mortality Review Committee

NOTIFICATION OF CLIENT/RECIPIENT/RESIDENT DEATH

(Type or print all information. When attaching additional sheets, clearly indicate which answer is being continued.)
THIS DOCUMENT CONTAINS CONFIDENTIAL MEDICAL INFORMATION AND
IS NOT SUBJECT TO DISCLOSURE AS A PUBLIC RECORD.

TO: Mortality Review Committee
Bureau of Quality Improvement Services
402 West Washington Street
P.O. Box 7083
IGCS, Room W451
Indianapolis, IN 46207-7083
Fax: Lynn Underwood (317) 234-2225
Phone: Lynn Underwood (317) 234-1146

FROM: Agency_____
Address_____
_____
City, State, Zip_____
Contact Person_____
Name & Title
Phone _____

Name of Deceased:_____

Date of Birth: ____/_____/_____ **Age at Death:**_____ **Social Security Number:** _____

Gender: Unknown **Race:**_____ **MRC #:** _____
(assigned by BDDS)

Address of deceased: _____

_____

Was deceased ever a resident of a State Operated Facility? Unknown

If yes, indicate facility and discharge date: _____

---------REPORTING CONTACT VERIFICATION---------

Date of this Report: _____/_____/_____

Contact	Date	Time	Name of Person Contacted	How Notified	Notified by Whom *
BDDS (required)					
APS (required)					
Law Enforcement					
CASE MANAGER					
LEGAL GUARDIAN					

* Indicate title of each if different from person completing this form.

Contact Information for individual listed above:

Legal Guardian: _____ **Legal Guardian's address:** _____

_____

Case Manager: _____ **Case Manager's agency & address:** _____

_____

Law Enforcement: _____ **Law Enforcement agency & address:** _____

_____

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- - - - - INFORMATION REGARDING DEATH - - - - -

1. Date of Death:_____ **2. Day of Death:**_____ **3. Time of Death:**_____

4. Address where death occurred: _____

_____

5. Type of setting where death occurred: _____

6. Name of setting where death occurred (if applicable)**:** _____

7. Primary cause of death: _____

8. Secondary cause of death: _____

(Attach a copy of the Death Certificate. Death Certificates are available as a public record from the County Departments of Health)

9. Was a terminal illness diagnosed? Unknown **10. If yes, Date of diagnosis:**_____/_____/_____

11. Identify terminal illness: _____

12. Name, Position, and Relationship to client of person(s) present at the time of death:
(If staff are listed, indicate which agency employs them - attach an additional sheet if necessary)

Name: _____**Position:** _____ **Relationship:**_____

Name: _____**Position:** _____ **Relationship:**_____

Name: _____**Position:** _____ **Relationship:**_____

Name: _____**Position:** _____ **Relationship:**_____

Name: _____**Position:** _____ **Relationship:**_____

13. Name of Physician Attending at time of death: _____
(if different from Primary Physician)
14. Address of Attending Physician: _____

_____

15. Phone number of Attending Physician: _____

16. Postmortem Reports:

a) Was an Autopsy Completed? Unknown **If yes, attach a copy of the autopsy report**

b) Is this death a Coroner's Case? Unknown **If yes, attach a copy of the Coroner's Report**

17. Autopsy Authorized by Whom/Relationship: _____

18. If no autopsy, indicate reason autopsy was not completed: _____

_____

_____

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19. Primary Physician's Name:_____

20. Primary Physician's Phone Number: _____

21. Primary Physician's Address:_____

_____

22. Date of client's last medical appointment with primary physician: _____/_____/_____

23. Reason for last medical appointment: _____

_____

24. Was physician notified of patient's illness prior to death? Unknown

25. Date of Notification: _____/_____/_____

26. Name and title of person notifying physician:_____

27. Have there been any reports, per BDDS reporting requirements, of Abuse, Neglect or Injuries sustained by deceased (for 12 months prior to death)? Unknown

28. If yes, attach a copy of the initial and follow up report, indicate the type of report and the date reported and attach any copies of relevant information relating to incidents that occurred prior to the individuals death:

Type of Report	**Date Reported**
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

29. Was an internal investigation of the death conducted? Unknown

If yes, attach a copy of the completed internal investigation report or submit when completed.

30. Date Completed: _____/_____/_____ **Or, targeted date of completion:** _____/_____/_____

31. If no, state the reason an internal investigation was not completed: _____

_____

_____

_____

_____

_____

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---------MOST CURRENT MEDICAL INFORMATION---------

32. Medications Prescribed - Attach actual physician order sheet if available (Attach additional sheet if necessary)**:**

Name of Medication	Dosage	Frequency	Date/Time Last Given

33. Current Diagnosis: _____

_____

_____

34. Past Medical History: Submit a copy of Medical history from individual's file, including copies of any medically related charted information. This should include the most recent history and physical completed by a physician in the last year, physician consults, Diagnostic tests and Lab tests (Only if not available, write information chronologically – attach an additional sheet if necessary)

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---------HOSPITALIZATION INFORMATION---------

35. Was the client hospitalized in the 12 months before death? Unknown
If yes, list name of hospital, date(s) of admission(s) / date(s) discharged / reason(s) for hospitalization. (Attach hospital discharge summary for each hospitalization) (Attach additional sheet if necessary)

A. **Name of Hospital:** _____

Address of Hospital: _____
Date of Admission: _____/_____/_____ **Date of Discharge:** _____/_____/_____
Reason for hospitalization: _____
Physician's orders upon discharge: _____

_____

_____

B. **Name of Hospital:** _____

Address of Hospital: _____
Date of Admission: _____/_____/_____ **Date of Discharge:** _____/_____/_____
Reason for hospitalization: _____
Physician's orders upon discharge: _____

_____

_____

C. **Name of Hospital:** _____

Address of Hospital: _____
Date of Admission: _____/_____/_____ **Date of Discharge:** _____/_____/_____
Reason for hospitalization: _____
Physician's orders upon discharge: _____

_____

_____

D. **Name of Hospital:** _____

Address of Hospital: _____
Date of Admission: _____/_____/_____ **Date of Discharge:** _____/_____/_____
Reason for hospitalization: _____
Physician's orders upon discharge: _____

_____

_____

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---------ADDITIONAL INFORMATION---------

☐ **36. Provide copies of the original charted data in the individual's file for the 30 day period prior to the individual's death. This should include the charted data for the individual such as chronological notes and habilitation notes from all service Providers, and staffing schedules up to and including the date of death. (If the individual died in a hospital setting, provide copies of the original charted data in the individual's file for the 30 days prior to hospitalization.)**

☐ **37. Please include a copy of the Individual Support Plan and Behavioral Plan.**

38. Please give any additional information that you feel is pertinent to this report:

39. If any of the following apply to the individual, please provide the information listed below or indicate that it does not apply: (if any of the requested items were not maintained, please provide a detailed response of all steps/action taken to assure appropriate care was provided to the individual)

a. If the individual experienced or had a diagnosis (current or historical) of Seizure Disorder:

- Neurological Records
- Seizure Records
- Policy for Neurology visits
- Medication History – specifically note any changes in seizure or psychotropic medications
- Documentation of any constipation, input/output records, or elevated temperature

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b. If the individual experienced Choking and or Aspiration:

- Assessments utilized to develop the dining plan – Indicate if a dysphasia assessment was completed
- Clarification of risk determination
- Chronological sequence of events and action during the incident (step by step action taken as a result of the incident)
- List of individual's present and their Staff training records to specifically note if training had or had not been provided and current for First Aide and suctioning.
- Copy of dining plan including staff supervision and adaptive devices

c. If the individual experienced any Heart Related concerns:

- Cardiac Assessments
- Complete medical history
- Chronological sequence of events and action during the incident (step by step action taken as a result of the incident – including First Aide provided)
- Policies and procedures on notification of Doctor of changes in medical condition
- Policy and procedures on reviewing care received during hospitalization
- Policy on the provision of CPR

d. If the individual experienced alleged or substantiated Abuse and or Neglect in the 6 months prior to their death:

- Staff training curriculum
- Documentation that staff present for the 7 days prior to death have had training
- Policy on investigation to make a determination to Substantiate Abuse and/or Neglect
- Policy on identification of high risk individual / abuse and/or Neglect management, individualized plan to ensure the individual's safety and well-being
- Policy on staff to consumer interaction
- Documentation of training provided to staff on identification of stress of staff or possible signs of abuse (indicate position of the staff and their level of interaction with the individual and the individual's direct care staff)
- Copies of all documents related to the internal investigation – including reports regarding all allegations of abuse and/or neglect in the past six months.

I hereby verify that the information contained in this report is accurate:
(Must be verified by Agency's Executive Officer)

_____
Signature

_____
Printed Name and Title

Date Verified: _____/____/_____
Phone Number: _____